Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TEXAS 77504

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-06-5251-02

DWC Claim #: X2601728
Injured Employee: CASSANDRA A RUSSELL
Date of Injury: APRIL 11, 2003
Employer Name: NEIMAN MARCUS GROUP INC
Insurance Carrier #: 949730602

Carrier's Austin Representative Box

Box # 01

MFDR Date Received

April 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated April 25, 2006: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). The total audited charges at issue in this matter exceed the Stop Loss Threshold. This rule does not require Vista to provide evidence that the services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached."

Amount in Dispute: $37,431.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 27, 2006: "Paid inpatient services per Texas Fee Schedule after auditing billed charges. Disallowed personal items not reimbursed ($46.75) adm kit, pt bag, lotion, soap. Disallowed charge for venipuncture ($11.50) as included in lab fee. Disallowed items included in facility fee ($6,970.90) – port x-ray charge, exam gloves (31 exam gloves for $196.00), sheet thyroid, blanket, cover mayo, headlight, light source, towels, headrest, pillow, corrugated blue tube, vest cool, Jackson table, c-arm and including charges for second item on date of service – suction regulator, flowtron DVT pump, flowtron DVT tubing. Implants paid per comparable implants per in-house invoices, as there were no wholesale invoices attached to bill."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Rd., Gainesville, GA 30504

Respondent's Supplemental Position Summary Dated November 30, 2011 and January 31, 2012:
"Requestor has not met its burden of demonstrating unusually extensive services, and the documentation

adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, Respondent appropriately issued payment per the standard Texas surgical *per diem* rate. No additional monies are due to the Requestor."

Response Submitted by: Hanna & Plaut, LLP, 211 East Seventh St., Suite 600, Austin, TX 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 29, 2005 through May 1, 2005	Inpatient Hospital Services	$37,431.64	$1,823.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- Z585 – The charge for this procedure exceeds fair and reasonable.
- Z695 – The charge for this hospitalization have been reduced based on the fee schedule allowance.
- X094 – Charges included in the facility fee.
- X668 – Venipuncture charges are included in the global lab fees.
- Z560 – The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- Z140 – Payment by the carrier will be according to the medical polices and fee guidelines established by the commission.
- Z989 – The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
- M-No MAR.
- F-Reduction according to fee guidelines.
- G-Include in global.

Dispute M4-06-5251 was originally decided on October 14, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-09-1037.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a February 16, 2009 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?

5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The documentation filed to the division by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges ***in this case*** exceed $40,000; the admission and disputed services ***in this case*** are unusually extensive; and that the admission and disputed services ***in this case*** are unusually costly.

1. The requestor in its position statement asserts that "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes "Z585, Z695, X094, X668, X560, Z989, Z140, M, F and G".

   These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $61,458.45. The division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "…if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). The total audited charges at issue in this matter exceed the Stop Loss Threshold. This rule does not require Vista to provide evidence that the services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is

not supported. The requestor failed to discusses the particulars of the admission in dispute that may constitute unusually extensive services, therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

4. In regards to whether the services were unusually costly, the requestor states "…This rule does not require Vista to provide evidence that the services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology." The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is not supported. The requestor failed to discusses the particulars of the admission in dispute that may constitute unusually costly services, therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.
   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $78,988.00.
   - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
ACIF TI-PEEK	1	$2800.00	$3,080.00
Screw Spinal Solution	4	$800.00/each	$3,520.00
Plate Cervical	1	$1,500.00	$1.650.00
TOTAL DUE	6		$8,250.00

The division concludes that the total allowable for this admission is $10,486.00. The respondent issued payment in the amount of $8,662.20. Based upon the documentation submitted, additional reimbursement in the amount of $1,823.80 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $1,823.80 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

	Elizabeth Pickle, RHIA	
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.